Chapter 16

Employee Assistance Programs in the Year 2002

Dale Masi, D.S.W.
Professor, University of Maryland; President/CEO, Masi Research Consultants Inc.

Laura Altman, Ph.D.
Principal, Towers Perrin

Charles Benayon, M.S.W.
Vice President, Business Development, Warren Shepell Consultants

Heather Healy, M.S.W.
Association of Flight Attendants

Donald G. Jorgensen, Ph.D.
President, Employee Assistance Professionals Association

Renee Kennish, M.A.
Vice President of Service Delivery, Ceridian Corporation

Deborah Keary, M.L.S.
Director of the Information Center, Society for Human Resource Management

Christina Thompson, M.S.W.
Vice President, Clinical Services, Magellan Behavioral Health

Barbara Marsden, M.S.W.
Accreditation Chair, EAP Society of North America

Bernard McCann, M.S.
Office of Demand Reduction, Office of National Drug Control Policy

George Watkins, M.A.
President, Performance Press Plus

Charles Williams, M.P.H.
Senior Public Health Advisor, Office of Managed Care, Center for Substance Abuse Prevention

Introduction

From its beginnings in the late 1970s, the employee assistance (EA) field has evolved into a full-fledged professional service addressing myriad personal and organizational needs in today's economy. Like the business community in which they exist, Employee Assistance Programs (EAPs) now find themselves in a period of significant transition. This chapter presents the current status of EAPs from eight different perspectives: (1) an overview, (2) program models and funding mechanisms, (3) integration of services, (4) professional certification, (5) accreditation, (6) international context, (7) training and professional development, and (8) research. It concludes with a section on future trends.

Overall Picture

EA efforts began as occupational alcoholism programs staffed by workers who had achieved sobriety. These workplace efforts have evolved into

broad-based programs delivered by a variety of practitioners drawn from a multitude of disciplines: psychologists, social workers, work/life professionals, substance abuse specialists, and marriage and family therapists. These professionals help employees and their dependents manage and respond to the full range of mental health difficulties, from diagnosed mental disorders to the personal concerns regarding marital, parental, and family upsets; work stress and work/life issues; financial and legal issues; and substance abuse.

The growth of managed behavioral health care (MBHC) spurred the collateral growth of EA efforts. Conceived to combat spiraling medical costs, managed care was envisioned as a method of reducing expenditures while ensuring that appropriate levels of care were maintained. MBHC often provides near-identical features with EA services, and consolidation in the behavioral health and EA fields has lead to the development of integrated EA/managed care products.

The emergence of drug-free workplaces in the 1980s as the standard for American industry has been another important factor with an impact on EAPs. EAPs that use a combination of supportive assistance and disciplinary action to address substance abuse integrated into a comprehensive drug-free workplace approach have enjoyed the greatest success.

Presently, the EA industry is going through fundamental changes that reflect the needs of corporate clients. Many contemporary EAPs combine EA assessment, referral, and case management with a broader work/life umbrella approach. These broad-brush EAPs, designed to be one-stop shops for mental health needs, have become a core employee benefit. This trend of EA service delivery will likely be continued for the next decade by the more adept EA providers and will increase market consolidation.

The current market opportunities for EA products in the United States are in the small and medium-sized employer sectors. The majority of Fortune 1000 companies and larger employers have mature programs, some more than 20 years old. Other prospects for future market growth include the development of specialty-type markets and expansion into the international arena. Continued pressure on pricing and profits will be difficult to overcome. Efficient service delivery, improved product quality, enhanced product development, and effective marketing will all be important competitive factors. At this point, effective marketing may be the most crucial factor.

Challenges

The EA industry is fairly fragmented, with no undisputed industry leader. Cross-industry collaboration in several areas would allow professional associations to combine resources and move the field forward in an efficient and timely manner. Purchasers increasingly are expecting EA providers to deliver value while demonstrating quantifiable returns on their investment. To meet these expectations, EA professional organizations must emphasize accountability through quality improvement, surveys, and evaluation efforts. In addition, new technology platforms to enhance EA services are needed.

Numerous challenges exist within the behavioral managed care arena. For example, if MBHC firms also provide an EA service component, that component suffers from at least the appearance of a conflict of interest, given managed care's focus on limiting treatment costs as well as its profit motive. Further, if managed care incentives emphasize cost containment over appropriate levels of care, conflicting program goals may arise. Conversely, if incentives allow freer access to treatment, commitments to contain costs may suffer. Achieving an equitable balance between EA and managed care functions will allow the two approaches to blend more effectively.

Opportunities

With the terrorist attacks of September 11, 2001, the need for EAPs has never been so clear. The immediate impact of September 11 on the EA industry was immense. In the weeks following the attacks, one provider's requests for critical incident debriefings increased 3,000 percent. Another EA provider conducted 41 critical incident stress-debriefing (CISD) sessions with 24 companies in seven States within one week. The Employee Assistance Professionals Association's (EAPA) switchboard was flooded with media inquiries and requests for referral to EA professionals, grief counselors, and CISD providers.

EA professionals also will find tremendous opportunities in the area of behavioral risk management, program evaluation, organizational development, and human resource and benefit management functions. Many EAPs have begun assuming functions typically associated with managed care in the area of mental health and alcohol and drug abuse. Assigning EA personnel responsibility for behavioral health care coverage carve-outs and

empowering them to negotiate contracts for clinical services can dramatically reduce costs for organizations while providing quality mental health services for workers and their dependants.

EAPs continue to have opportunities to demonstrate their value by helping organizations cope with the increasing stress and complexity of today's workplace. EA personnel will continue to remain the first point of contact for employees and their family members experiencing personal concerns. The current unprecedented demand for EA services is an opportune occasion to firmly position EAPs as an integral part of the new workplace environment and as the entry point for the system of mental health and substance abuse services.

Program Models and Funding Mechanisms

No single example can succinctly describe the various models of EAPs. Instead, descriptive terms have evolved over time that focus on aspects of service design and delivery. Reflecting the wide diversity in types of organizations that sponsor EA efforts, delivery models of EA services are many and varied. However, there appears to be a practical and functional aspect to distinguishing EAPs along a number of discrete dimensions.

Session Limitation

The Assessment and Referral Model typically offers up to three EAP sessions focused on problem identification and linkage to an appropriate outside resource for problem improvement or resolution.

The Short-Term Problem Resolution Model offers additional sessions beyond the assessment process when it is determined that the assessed problem can be improved or resolved using EA services. When the assessed problem cannot be adequately addressed through additional EAP sessions, the EA professional provides appropriate linkage to outside resources. Typical short-term problem-solving models offer four to eight sessions, inclusive of the assessment session(s).

Range of Services

The Basic Model offers the core services of a traditional EAP, including consultation with appropriate persons in the identification and resolution of job performance issues, problem assessment, referral and followup services, organizational consultation, program promotion, and education.

The Add-on Service Model offers a menu of related services in addition to core EAP services. These services might include critical incident response, wellness training, work/life services, legal assistance, financial services, and so on.

Relationship With Behavioral Health Services

The Stand-alone Model is one for which no service relationship exists between the EAP and the behavioral health services available to beneficiaries.

The Integrated Model is one in which the EAP and the behavioral health services available to beneficiaries are purposefully interrelated in a predefined capacity by the sponsoring organization(s). For example, the EAP may serve as the required gateway to behavioral health services.

Service Location

In the *On-Site Model*, EA services are delivered on the property or worksite of the sponsoring organization(s).

In the *Off-Site Model*, EA services are delivered at a location other than the worksite or property of the sponsoring organization(s).

In the *Virtual Model*, EAP services are delivered by telephone or online, eliminating the issue of EAP office location. The virtual site has been used extensively for delivering "add-on" EAP service, such as work/life services, health promotions, employee education, organizational training, and mental health screenings. Online delivery of core EAP services is gaining momentum as the industry develops standards and protocols for optimal efficiencies and client protection.

The *Mixed-Site Model* is a blend of onsite, offsite, and virtual sites made available to beneficiaries.

Service Provider

In the *Internal Model*, staff or members of the sponsoring organization(s) provide services.

In the *External Model*, services are outsourced to an external EA provider.

In the *Mixed/Blended Model*, services are delivered using a customized mix of internal and external providers. For example, the administrative functions of the EAP could be managed by internal staff while an outside vendor provides assessment services.

In the *Peer Model*, trained peers or colleagues, using a social support framework, provide early identification, intervention, and referral to support services for problem resolution.

In the *Affiliate Model*, a network of contracted behavioral health care providers is available to provide EAP services within a specified distance from home or work. This model has become increasingly popular with organizations that need to address equity in EAP service accessibility and delivery because of multiple, dispersed, global, or alternative worksites.

Service Eligibility

The EAP typically is designed to assist employees of the sponsoring organization(s). Family members of employees may often use the services as well. The relationship between the sponsor and the beneficiary of EAP services is not always an employer-employee construct. The term is sometimes used to describe the universe of EA programs without consideration of the model.

In the *Employee and Family Assistance Program*, the inclusion of the term "family" in the name purposefully highlights the availability of services to family members. The definition of "family" may vary by programs and may or may not address the issue of domestic partner coverage.

The *Member Assistance Program (MAP)* is designed to serve members of the sponsoring organization(s). Labor unions or professional associations, for example, may sponsor MAPs. Though not included in the name, family members may be covered.

The *Labor Assistance Program (LAP)* is designed to assist workers who are members or employees of the sponsoring organization.

Sponsor/Payer of Service

In the *Management Model*, an employer, business, or corporation sponsors the EAP as a risk management tool to reduce liability related to troubled employees. Although various models are described, the Management Model is clearly the one most used.

In the *Colleague Model*, the sponsoring organization is typically a professional association often acting with or under a level of authority and funding from a State licensing/certifying board. Offering support and rehabilitation to colleagues while simultaneously protecting the public from harm is a primary focus of this model.

In the *Consortium Model*, the combined resources of member organizations fund services. Consortia are often composed of small to medium-sized organizations seeking quantity discounts.

In the *Joint Labor/Management Model*, services are jointly funded and managed by labor and management. This model recognizes the collective benefit to both groups of assisting workers.

In the *Union Model*, the sponsoring entity is a labor organization whose mission is enhancing the health and welfare of its members and their families.

Integration of Services

Managed Behavioral Health Care

The most common form of EA integration is between an employer-sponsored MBHC benefit and its EAP. In this section, the phrase "managed behavioral health care" refers to both mental health and substance abuse. "Integration" refers to programs and services that are accessed through a single point, usually a toll-free telephone number. Integrated programs attempt to streamline beneficiaries' ease of use throughout the continuum of service. They also allow for customization and alignment of plan designs, ongoing coordination of services, reduction of service duplication, continuity of care, and minimization of cost-shifting. A key to ensuring ease of access to services is program promotion, employee education and wellness, and human resources staff competence training.

An extension of the integration between EAPs and MBHC benefits is the evolving linkages between EAPs and other services. These other services include, but are not limited to, work/life services, drug-free workplace programs, CISDs, Web-based EAP products, psychiatric disability and disease management programs, and the still-evolving e-

therapy services. Internal and external EAPs play various roles in the integration with MBHC, from a simple intake capacity with the MBHC plan providing referrals to models in which the EAP provides assessment, referral, and managed care services as well. In these (less prevalent) models, the EAP contracts with a treatment provider network, and the employer's needs govern the type of EA services provided.

EAPs Integrated With Work/Life Services

A recent phenomenon for EA service provision is its integration with work/life services, such as child care and elder care resources and referral. The early 1980s were a growth period for work/life services as women began to enter the workforce in much larger numbers. Employers became aware of the need for quality child care to support the two-parent workforce. By 1985, several private companies were administering resource and referral services for large multisite employers, primarily assisting employees in finding and managing child care arrangements. As the 1980s progressed, baby boomers began to experience significant issues with their elderly parents. The addition of elder care services to the work/life field was a controversial development. Many EAPs had already been providing services in the elder care area, and the issue was whether work/life programs or EAPs were more appropriate for handling elder care. At this time, no evaluations have been performed to ascertain the better model for service delivery.

The work/life companies moved away from addressing only dependent care issues toward a holistic approach to providing support to the workforce, addressing the broader notion of finding balance between work and family. Additional services were developed—educational, concierge, financial, and legal service, for example—to appeal to a more diverse audience. In the mid- to late 1990s, it became clear that the EAP and work/life fields needed to partner in their support of a productive work environment by offering employers an integrated model of service—one-stop shopping. In the late 1990s, many larger national EAPs merged with work/life companies or developed partnerships to support an integrated model of service delivery.

Web-Based Services

Many EAPs have begun to offer Web-enabled services. The Internet provides client organizations with a platform for inexpensive, yet customized, EA promotional information via intranets and e-mails. Web-based EA products offer a wide range of services, including notification of company benefits and policies; preventative education; multimedia access to early, confidential self-assessment services; resources and tools for managers; multimedia access to coaching and mentoring instruments or literature; access to training modules; and continuing support via chat technology. Common offerings are mental health clinical content, which may include tip sheets, wellness information, assessment and screening tools, and helpful articles on a variety of topics. These services are offered through self-assessment tools and dial-a-counselor programs. Perhaps most compelling is the technology's round-the-clock availability, which accommodates different work schedules and locations while offering privacy and confidentiality and may increase access from those client segments most hesitant about seeking traditional face-to-face counseling. The National Board of Certified Counselors has developed one notable set of practice guidelines for certified counselors for delivering online mental health services (posted on its Web site: http://www.nbcc.org/ethics/webethics.htm).

One of the most common methodologies for Web-based services uses an asynchronous approach, the other a synchronous approach. Asynchronous Web-service communications occur with the EA professional and the client working at different times. E-mail and instant messaging are examples. Asynchronous Web services can also be used to provide psychoeducation or Web-based bibliotherapy. For the former, the EA professional would refer the client to informative Web sites and other electronic sources of information. With the psychoeducation approach, an EA professional must be competent to recognize when to move the client into more traditional face-to-face services, as appropriate. Synchronous Web-service communications occur simultaneously (in real time) using interactive electronic technology, such as video and voice or audio via computer, with no lag between interactions. Chat room technology is an example.

EA professionals understand that the Internet is not appropriate for all clients at every level of service but that it is part of a continuum of options. The eventual promise of Web-based technology to successfully deliver services beyond mere health ed-

ucation is not that far in the future. Evaluation of such services is needed.

Drug-Free Workplace Programs

In 1988, the U.S. Congress enacted the Drug-Free Workplace Act, which requires most Federal contractors and grantees to certify that they have established a drug-free workplace program containing basic mandated elements. These elements include developing and communicating a drug-free workplace policy; distributing information about the dangers of workplace drug abuse and opportunities to get help; and reporting workplace drug convictions. They do not mandate, but suggest, the development of EAPs. Subsequently, other industry sectors with safety and national security concerns, such as transportation, nuclear energy, and defense contracting, have come under additional Federal agency drug-free workplace requirements, including drug and alcohol testing. In general, employment positions with safety-sensitive duties are likely to require drug and alcohol testing.

EAPs may offer several types of drug-free workplace-specific services to employers, including training supervisors to recognize the signs of alcohol and drug abuse, conducting employee drug and alcohol educational efforts, establishing and administering testing programs, and providing Substance Abuse Professionals to conduct substance abuse assessment, referral to treatment, and followup monitoring when employees return to work.

Critical Incident Stress Management

EA providers may offer critical incident stress management (CISM) services as part of their product line. A critical incident is defined as a sudden, unanticipated situation or circumstance that produces a high degree of distress, such as national disasters, accidental or sudden deaths, assaults, workplace accidents, robberies, homicides, suicides, and terrorist attacks. Varying program responses may be effective after these events, depending on the intensity or details, the culture of the organization, and the level of impact on an individual worker or groups of workers. These responses are known as defusing and debriefing. Defusing occurs within hours after the event; debriefing could be provided within 24 to 48 hours following the event. Therapeutic activities include normalizing feelings; encouraging discussion through a review of the facts; surfacing the participant's thoughts, feelings, and reactions; identifying employees who are experiencing severe reactions; and supporting the individual's coping mechanisms to relieve fears and anxiety around the event. This type of support can range from Web-based education and information to telephonic assistance, onsite support, face-to-face assessment and counseling and followup.

Providing support and consultation to management after a critical incident is also necessary, and EAPs typically play a key role. Management should be educated regarding what to expect, likely reactions, performance issues, and types of resources available to employees and dependents. Since the September 11, 2001, attacks, EAPs have added terrorist activity to the list of critical incidents to which they are prepared to respond. EAPs can consult with management on development of disaster recovery and emergency response plans for any contingency. These proactive approaches can range from education, stress inoculation, and fear reduction to recovery and relocation plans and backup strategies to help keep workers safe and help them return to productivity as soon as feasible.

Psychiatric Disability Management Programs

Over the past decade, the impetus for the development of enhanced disability management products was the rapid growth of employers' disability costs, an increasing percentage of which costs are due to behavioral health disabilities. Evolving disability management products focus on early identification of potential or actual cases, accelerated access, intensified treatment provided by specialty-trained providers, integrated treatment teams, and return-to-work facilitation and followup. In addition to case management services, specialty case managers provide workplace assistance to supervisors, help with modified duty schedules, and help with reasonable accommodation approaches and preparation of the work group to ease the returning employee's reentry into the workforce. Administration of a managed psychiatric disability program usually is coordinated with an employer's general disability administrator and with the benefits department.

Professional Certification

Established in 1986, the Employee Assistance Certification Commission (EACC) administers a professional credential, the Certified Employee Assistance Professional (CEAP©), to identify EA practitioners meeting established standards for competent, client-centered practice and adhering to an enforceable code of professional and ethical conduct. Each candidate must meet experience, professional development, and advisement requirements and pass a qualifying examination. The EACC remains the autonomous credentialing body responsible for all aspects of the CEAP© program, including establishing policies and procedures of the CEAP© credential; developing examinations; and enforcing ethics codes. In January 1987, the EACC commissioners approved the CEAP© designation for those successfully completing certification requirements. As of December 2001, over 5,500 CEAPs© were practicing in the United States and in 16 other countries.

Future Trends in EA Professional Certification

The EACC and the CEAP© credential continue to evolve. A new version of the CEAP© examination debuts in May 2002, reflecting revised job requirements identified by a recent role delineation study. It will include test questions based on different cognitive levels. Application and analysis skills are integral to competency in EA practice, and items to assess these two higher cognitive levels are now incorporated. To make certification, already widely recognized in the United States and Canada, more accessible to those in the international community, the EACC has adopted revised advisement requirements and developed internationally relevant versions of the examination.

In response to the EA profession's increasingly sophisticated professional development needs, the EACC continues to prepare for advanced certification, such as a master's-level CEAP© and the possibility of providing subspecialty credentials, such as a Substance Abuse Professional and CISD certification. The U.S. Army recently adopted the CEAP© credential for its civilian and uniformed employees working as substance abuse specialists.

EAP Accreditation

In 1981, the Standards for Employee Alcoholism and/or Employee Assistance Programs were drafted by a joint committee representing the Association of Labor/Management Administrators and Counselors, the National Council on Alcoholism, the Occupational Program Consultants, and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). From this early effort until today, the need for program standards and practice guidelines has taken on increasing importance in the EAP field. Although both the EAPA and the Employee Assistance Society of North America (EASNA) have actively supported the need for international standards of practice, only two organizations are accrediting EAPs today:

The Council on Accreditation (COA) began accrediting EA service providers as components of child and family service organizations in 1987. Of more than 100 EAP services accredited under this process, most are part of larger multiservice child and family organizations in the United States and Canada. In 2001, COA expanded its accreditation of EAPs by collaborating with EASNA to create a separate book of standards for stand-alone EAPs. In June 2002, COA became the EA accreditation service provider and will own the new revised standards to be published in the latter part of the year.

The Council on Accreditation of Rehabilitation Facilities (CARF) established an EAP accreditation product in 1988. Most of the 21 EAPs receiving CARF accreditation to date are provided through community human service organizations or EAP counseling agencies.

Many different market forces have led to the increasing importance of accreditation in the EA field. The consolidation of EAPs throughout North America has increased the visibility of accreditation and the need to use accreditation as a means of differentiation and quality improvement. Accountability to internal and external stakeholders has also increased, and accreditation is one tool that an EAP can use to demonstrate accountability. The search for a common language for the field and common definitions of what constitutes a case or how utilization is determined has led EA service providers to adopt accreditation as a means of standardization. EAPs have also moved toward accreditation as a way of self-regulating to prevent excessive oversight or regulation at the Federal or State level.

Typically, an EAP undergoing the process of accreditation engages in a period of self-study and evaluation during which the EAP itself determines

whether it complies with a set of best practice standards. If it does not comply, the EAP typically takes time to rewrite policies and implement new procedures. Once an EAP has determined its readiness for accreditation, it submits presite documentation to demonstrate its compliance with each best practice standard. After studying the materials and assigning presite scores, peer reviewers or surveyors visit the EAP to ensure onsite compliance with the standards. Following the site visit, the EAP receives a detailed report showing areas of compliance and areas that need improvement. Once an EAP has met a certain level of organizational compliance, it is awarded an accreditation.

Additionally, the Substance Abuse and Mental Health Services Administration (SAMHSA) is continuing to provide support for standards development for other EA services, such as member assistance programs, student assistance programs, integrated EAPs, and consortiums or public EAPs. SAMHSA is also supporting an effort to collect data during the accreditation process to develop performance benchmarks and outcome measurements for the EAP industry and, thus, better inform the industry of what constitutes a best practice. The University of Maryland works with COA in this effort.

With the rapid changes occurring in the EAP field and the increasing importance of its services, maintaining international standards of best practice and demonstrating quality improvement is important not only for the EAP but for the many people it serves. The quest for this measurement of quality seems to be achieved best through the accreditation of EAPs.

EAPs in an International Context

Until 1996, cross-cultural research data identifying the extent and nature of EAPs from a global perspective were lacking, challenging any appreciation or evaluation of the uniqueness of different cultures and their respective responses to workplace mental health needs. With the publication of the *International Employee Assistance Anthology* in 1996 and its second edition in 2000 (Masi, 1996, 2000), a consolidation and documentation of EAP data from an international perspective emerged. EA activities in more than 40 countries were included in each of these publications. Information was collected for each country in the areas of psycho-socioeconomic climate; health and welfare system particulars; relevant social work legislation; the history, development, and current state of EA or occupational health; and any emerging trends. For the international EA community, the collected information does the following:

- Highlights the diversity and uniqueness of regional workplace-based mental health issues
- Acknowledges the relative understanding by employers of mental health issues by considering responses by country
- Demonstrates the differences, strengths, and gaps inherent in each country's EA service delivery models
- Clarifies the differences between EA and occupational social work, which may coexist in various regions
- Identifies an overarching concern for the negative effects of substance abuse on employees
- Identifies rising health care costs as a shared international concern
- Reinforces the role of organized labor as a stakeholder in workplace-based assistance programs in countries where a majority of workers are union members

The anthologies also illustrate, by their omission, those countries not currently providing mental health assistance to employees, or at least not in a manner resembling North American standards. Although the anthologies provide one of the few comprehensive summaries of international EA efforts to date, some organizations have worked toward development of standard practices in the EA international arena. In 1996, representatives of the EAPA from 14 countries developed guidelines for international EAPs designed to be applicable in different locales and cultures. With the recent partnership between EASNA and COA, international EAP accreditation standards that will have broad applications to the practice of EA across global borders are under development.

In Europe, although the appearance of EAPs is relatively recent, the professional discipline of occupational social work has a long history in many countries and is represented by the European Network of Occupational Social Workers (ENOS), founded in 1990. ENOS's primary mandate is to act as a transfer point for the exchange of information between occupational social work representatives

from each European country. Although different in nature and mandate than EAPs in North America, the network of occupational social workers provides some functions for European employers similar to those provided by EAP practitioners in North America.

In Australia and New Zealand, a relatively robust EA industry exists, with an estimated 30 percent market penetration (Hopkins, 1999). In Latin America and Asia, the initial appearance of EA was largely initiated by the needs of multinational companies and consortia to provide EA services to expatriate employees, although many of these multinationals have begun to extend program services to in-country workers and other worksites as appropriate to the local market and climate.

World Strategic Partners is an international health industry network whose mandate is to empower and influence health and policy leaders to succeed by providing access to its professional network, international health care initiatives, and a forum for knowledge exchange. World Strategic Partners hosts an annual Global Symposium at the International Labor Organization in Geneva, Switzerland, to reinforce the essential nature of the individual's well-being in relation to the employer's well-being. Key public and private sector leaders and decisionmakers from around the world gather at this symposium to address the global movement toward individual and organizational wellness.

As the movement for information sharing and standardization of practice increases, it is more apparent that external factors, such as the globalization of multinational corporate organizations, the lowering of barriers to the free movement of goods and services, the advent of the information superhighway, and other technological advancements, have created a new, wider lens through which to view the world. This evolution offers the opportunity to experience and understand global cultural differences and, in doing so, to learn about the many similarities that human beings share.

On a more practical scale, people worldwide continue to experience problems in their daily lives that have a negative impact on their ability to perform in the workplace and to contribute to the productivity of the organization. Mental health knows no geographical or socioeconomic boundaries. Although standards and practices may vary from country to country, the response to address employee mental health issues is born out of a commonality that transcends race, culture, language, and gender.

Training and Professional Development

Background

The earliest EA professionals were called occupational program consultants (OPCs). Many were senior employees who combined their business savvy and personal recovery from alcoholism to start industrial alcoholism programs to assist employees.

The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (often referred to as the Hughes Act after its primary sponsor, Senator Harold Hughes) established the NIAAA. In its groundbreaking *Special Report on Alcohol and Health* (1971), NIAAA estimated that five percent of the workforce suffered from alcoholism and another five percent were serious alcohol abusers. Pegging the annual cost of lost work time due to alcohol abuse and alcoholism at $10 billion, the report endorsed the therapeutic value of industrial alcoholism programs (see also United States Department of Health and Human Services, 1987).

NIAAA subsequently provided funding for 100 occupational program consultants (known as the "Thundering 100") who were instrumental in the rapid growth of many internally staffed corporate and union-based EAPs in the 1970s. OPCs successfully educated employers that proper assessment and opportunities for treatment combined with leveraging the employment contract could be instrumental in returning employees with performance problems to productivity. OPCs also consulted with employers in developing workplace policies and procedures for corrective action based on job performance, rather than alcohol use.

Professional Training

The diversity of backgrounds among EA practitioners has created unique training and professional development challenges for the EA industry. EA professionals have degrees and training in social work, psychology, psychiatric nursing, addictions counseling, and organizational development, to name a few.

To date, opportunities for higher education in EAP services have been limited, notwithstanding some notable exceptions—such as the University of Maryland's School of Social Work. The extent and

prevalence of EA courses in higher education is unknown. Columbia University and Hunter College offer occupational social work programs, which are similar to EAPs. Explanations for the reluctance of professional schools to develop and institutionalize EA training curriculums include the historical mix of EAPs from a broad range of disciplines outside academia and the difficulty of identifying qualified faculty with adequate knowledge and academic qualifications to champion such programs.

Given the relative lack of traditional academic pathways for EA professionals, the majority of initial and continuing education for EA practitioners has emanated from within the field. EA professional associations have labored to define the skills and expertise needed to provide quality, ethical EA services. The EACC's release of national standards for achieving EA professional certification, or CEAP©, in 1987 has been one of the major influences fueling the proliferation of professional development opportunities in the industry. These opportunities are typically delivered through national training conferences and institutes, as well as regional and local chapter meetings, although distance learning and Web-based professional development opportunities are proliferating, as they are in all occupations.

Larger EA and more recently integrated EA/MBHC organizations routinely provide inservice education to their employees, although some critics have observed that these types of training may tend to emphasize issues of procedure over issues of practice. Various union organizations, such as the Labor Assistance Professionals Association and the American Association of Flight Attendants, customarily provide specialized training for their members serving in union-affiliated programs. Other EA-related training for special applications, such as those serving as Substance Abuse Professionals under the U.S. Department of Transportation's regulatory requirement, have also been provided by various professional associations and for-profit groups.

Future Issues in Professional Training

As EA services have diversified and expanded from occupational alcoholism programs to broadbrush programs and the relatively recent work/life or work-family approach, employers have increased expectations of EAPs, creating demands for enhanced initial and continuing professional training. Issues such as workplace violence, threat assessment, critical incident stress, and work-family services were barely visible on the EA radar screen 15 years ago. The "outsourcing revolution" of EAPs from internal departments to external delivery systems integrated through EA/MBHC organizations can sometimes result in a blurring of EA services with mental health treatment and may lead to a perception that EA skills have narrowed to merely clinical counseling and case management services. The implication for EA professional development is that this shift may ultimately result in a universe of EA practitioners with limited organizational knowledge, skills, and practical workplace-based experience. And, if such a trend continues, increasingly fewer opportunities will be available to cultivate the organizational skill set that differentiates EA practitioners from other mental health care providers and counselors and that once was considered integral to internal EA services.

Familiarity with workplace substance abuse issues, historically a strength for EA professionals, appears to be a casualty of the new demographic profile of EA service providers. This circumstance, coupled with the ever-increasing scientific advances in understanding addictions and their application to EA practice, has returned the professional development issue to central importance.

No matter how broadly or narrowly defined, EA service providers must be able to address employee performance, workplace policy development, human resource management consultations, and supervisory and organizational development issues. There is a companion need to increase the level of understanding among human resource and benefit consultants by mainstreaming information about EAPs and required course work into the business and professional schools that train our future health and human service professionals.

Research

EA research efforts have been conducted with an eye to: (1) prevalence of EA services in the workforce; (2) studies of EA program characteristics and functions; and (3) outcome evaluations of EA service delivery.

Prevalence of EAPs

A 1985 survey conducted by the U.S. Department of Labor reported that just under one-quarter (24 percent) of mid- to large-sized private sector worksites (more than 50 employees) offered EAPs

(U.S. Department of Labor, Bureau of Labor Statistics, 1988). In 1988, the Bureau of Labor Statistics (BLS) conducted a more extensive survey, its *Survey of Employer Anti-drug Programs,* of 7,502 private sector employers of all sizes (U.S. Department of Labor, Bureau of Labor Statistics, 1988). Results of this survey estimated an overall prevalence rate for EAPs of 6.5 percent of worksites of all sizes, but these programs covered approximately 31 percent of U.S. employees. Additionally, about three percent of employers without EAPs were considering establishing one. The survey revealed that the most important factor in EA implementation was establishment size—76 percent of the Nation's largest establishments (1,000 or more employees) had instituted EAPs versus only nine percent of the smallest (fewer than 50 employees). Differences in EAP coverage were less by industry, although notable. The mining, communications, public utilities, and transportation industries were most likely to have EAPs, while the retail trade, service, and construction industries were least likely. This is not surprising considering that small employers dominate the latter industries—76 percent of construction and services establishments had fewer than 10 employees, as did 67 percent of retail trade firms.

In 1990, BLS conducted a followup study with a portion of the 1988 respondents. Results indicated eight percent of employers without an EAP in 1988 had one by 1990. Overall, the percentage of worksites offering access to EA services increased approximately five percent, from 6.5 to nearly 12 percent, with larger businesses starting programs at a much higher rate than smaller businesses (Haygue, 1991).

This trend of sustained EAP growth continued into the 1990s. The 1993 *National Survey of Worksites and Employee Assistance Programs,* a survey of more than 3,000 worksites, confirms EAP market share expansion to an estimated prevalence of one-third of mid- to large-sized U.S. workplaces (more than 50 employees). EAPs were more likely to be found in workplaces where employees were unionized, more educated, and with relatively fewer minority workers. Geography seemed to have no impact on the existence of programs. Additionally, this study reported a marked shift in EA service delivery—away from the historical onsite by internal EAP personnel to a majority (81 percent) of services provided by external vendors offsite (cited in Hartwell et al., 1996).

A special module of questions included in the 1994 and 1997 *National Household Survey on Drug Abuse* collected information on workplace substance abuse interventions, including EAPs (DHHS, 1999). Findings again illustrated a marked disparity in access to EA services relative to establishment size, although continued increases in overall EA coverage were evident. In 1994, 15 percent of workers in small establishments reported access to EA services. By 1997, this number increased to 28 percent, whereas 61 percent of workers in mid-sized establishments and 75 percent of workers in large establishments reported EA coverage.

Open Minds, a behavioral health industry research and consulting firm in Gettysburg, Pennsylvania, began its annual surveys of managed behavioral health and EA providers in 1994, reporting an estimated 27.2 million individuals enrolled in EAPs—20 million in stand-alone EAPs and 7.2 million in integrated EA/MBHC programs. By 2001, Open Minds estimates enrollment figures of 51 million in stand-alone EAPs and 15.5 million in integrated EA/MBHC programs—a 245 percent increase since 1994 and a 13.3 percent increase since 1999 (Open Minds, 2000). The Society for Human Resource Management's 2001 *Annual Benefits Survey* provides further testimony of strong market penetration, with 67 percent of 754 human resource professionals responding that their organization offers an EAP, five percent stating their organization plans to offer one in the coming year, and only 24 percent stating they do not offer one. Industries subject to government regulation and workplaces with more acute occupational safety concerns, such as energy, transportation, and public safety, almost universally provide access to EA services, in contrast to food service, hospitality, retail sales, and temporary or contract labor services.

Costs of EAPs

Fees for externally provided EA services are typically calculated annually on a per capita basis (i.e., number of employees multiplied by cost per year), although occasionally a fee-for-service arrangement is used. Program charges vary by company or worksite and are typically negotiated between provider and employer on an individual contract basis.

Differences in the type, extent, staffing levels, and expected use of services offered to program participants can affect cost proposals. Other cost factors have historically included size of employee population and number of worksites. Using a standardized approach, a Research Triangle Institute case study of seven different EAPs during fiscal

years 1991 to 1993 examined personnel, operating expenses, facilities, equipment, and supplies (Bray et al., 1996). Their comparative analysis estimated an annual EAP cost per eligible employee ranging from a low of $10.58 to a high of $181.47. The study noted that differences in delivery of services were major cost factors and also documented a consistent association of higher utilization rates with higher costs per employee. Another national EAP prevalence survey published in 1996 reported a national average of $26.59 for internal programs and $21.47 for external programs (Hartwell et al., 1996).

A survey of 185 multiemployer health plan administrators echoes other findings that EAP costs depend on multiple factors, including expected and historic utilization levels in a given group and whether the EAP is internal or external (International Foundation for Employee Benefit Plans, 2001). With 90 percent of fund administrators reporting that EA services were provided by external contractors, the average annual cost per participant was $29, and the median annual cost per participant to multiemployer funds was $25.

Over the past decade, costs for externally provided EAPs have remained stable, likely because of intense intramarket competition and the trend toward combining EA services with managed behavioral health and work/life programs as integrated products.

Quantitative and Qualitative Research

Compared with other mental health and related disciplines, the EA field has not produced a plethora of sophisticated or scholarly research. Reasons for this relative dearth of rigorous academic studies includes the aforementioned lack of programs at U.S. colleges and universities, the natural home of such activity.

The largely independent and self-funded nature of private sector EAPs is perhaps the best explanation for the relatively few large-scale research studies. However, many employers have undertaken their own internal evaluations of EAP cost-effectiveness and value to the client organization. Reports of these highly anecdotal reviews of program performance are typically written in business language using economic, rather than mental health, terms. Additionally, given their proprietary nature, some corporations have chosen not to publish such evaluation findings. However, the continuous, steady growth of EAPs in all types of workplaces suggests a widely held assumption among chief executive officers and human resource professionals that EAPs have a positive effect on the "bottom line."

Though EAP cost-effectiveness studies have recently become more empirically based, the literature tends to be dominated by studies that do not subscribe to high levels of scientific rigor or case studies without general application to the workforce. Some of this lack of empirical data is also attributed to a variety of issues long recognized as barriers in the mental health arena: difficulty in quantifying necessary variables, the need to respect client confidentiality, and a relative scarcity of resources.

Several authors have weighed in on both sides of this discussion and raised more specific issues. Collins (1998) suggests two explanations. First, he cites a short supply of analytical resources for both internal and external programs. Second, he maintains that absenteeism-coding formats, a widely accepted measure in the cost-effectiveness studies, are not uniformly recorded across the industry. Blaze-Temple and Howat (1997) add that many mental health care professionals lack both background and expertise in research, whereas Tramm (1990) cites the growing professionalism of the EA field, which increasingly includes graduate or higher academic degrees and has boosted the recognition of program evaluation as a valuable tool. Likewise, the most recent program standards from EA professional associations include periodic evaluation as an essential component of best practices.

Cost-Effectiveness Studies

Even with these qualifications, some researchers contend that EAPs tend to be on the leading edge of cost-effectiveness research in the behavioral health care field, perhaps because of the business influence. They suggest that EAP cost-effectiveness studies tend to fall into three categories:

(1) Pre/post-test designs with few outcome measures

(2) Comparison studies in which the control groups may or may not be legitimately matched

(3) Case studies of specific business concerns that may or may not build on existing models or operational definitions of outcome measures

DHHS's evaluation of the Employee Counseling Service (ECS) is a model for the use of a control group with repeated collection of measurable data. This model, developed in the mid-1980s, remains an industry standard of rigorous research design reviewing cost-effectiveness and cost-benefit of the ECS and more than 2,000 EAP clients. The study evaluated the components of context, inputs, process, impact, and outcomes with a client tracking system (CTS). The CTS measures client status, work performance by supervisors, and personnel data at intake, after three months, and after nine months. Results identified the dollar benefits in only six months of $1,274 per employee served; for every dollar spent, a return of $1.29; and an estimated five-year cost-benefit ratio of 13 to 1 (Masi and Maiden, 1985).

Masi Research Consultants conducted a study for the U.S. Postal Service in 1994, capturing data from one year before EAP entry to one year after, and examined health insurance claims, personnel and financial variables, workers' compensation claims, equal employment opportunity (EEO) costs, and employee job performance (Masi et al., 1995). Data from EAP clients were compared with a random sampling of non-EAP clients. On an order-of-magnitude basis, cost-benefit ratios conformed to prior results, with some of the greater returns in the EEO and workers' compensation areas.

A study of Virginia Power's EAP in 1991 used long-term longitudinal data to assess the program's cost-effectiveness. Medical claims data four years prior to and four years after introduction of the EAP were analyzed (Every and Leong, 1994). Results indicated that employee medical costs were 23 percent lower for EAP clients than for those accessing behavioral health care on their own. More surprising, the nonbehavioral-related medical costs showed a larger drop than the behavioral illness costs (32 percent vs. 17 percent).

The Chevron Corporation initiated two cost-benefit analyses in the 1990s: a return on investment (ROI) study and a post-substance abuse treatment analysis of safety records (Collins, 1998). The ROI study calculated the value of retention compared with new hiring and training, improved productivity for mandatory and formal referrals, and improved productivity for self-referrals. Combining the totaled estimates from these three categories resulted in savings of approximately $20.6 million over 5 years and, considering Chevron's EAP annual budget of $1.5 million, yielded a return ratio of 14 to 1.

The 1990 McDonnell-Douglas-Health Strategies study (Stern, 1990) is perhaps the best-known comparative study of the effectiveness of an EAP linked with behavioral health benefits. It compared employees who used the EAP to access treatment for alcohol, tobacco, and drug (ATD) dependency or psychiatric conditions with a control group of employees using services via traditional non-EAP sources. Followup case reviews revealed that ATD EAP clients missed 44 percent and psychiatric EAP clients missed 34 percent fewer workdays compared with the control group. Compared with the control group's 40 percent turnover rate, ATD EAP clients had a turnover rate of only 7.5 percent, and psychiatric EAP clients had a 60 percent lower turnover rate than the control group. Additionally, medical claims averaged $2,400 lower for EAP psychiatric cases than for employees who choose not to use the EAP and 35 percent lower for dependants who accessed treatment through the EAP.

Another type of cost-benefit analysis used monetized ratings for EA clients referred by a supervisor. The assumption employed by this analysis was that higher-rated employees are more productive than lower-rated employees and that productivity can be translated into dollar values. Scores at intake were compared with scores at 3 months and 9 months to obtain a 6-month value and multiplied by salary levels to obtain a dollar benefit value. The results revealed an ROI ratio of 13 to 1.

Future Directions

In spite of rapidly changing economic conditions that continuously create new challenges in today's work organizations, EAPs remain focused on providing quality support services to employers and their workers. Employers and other purchasers will continue to expect cost-efficient, integrated, and responsive EA service delivery. These services must be streamlined, be relatively simple to administer, and, above all, contribute to enhanced employee well-being and increased productivity. There appear to be at least three distinctive trends likely to affect the EA field in program service, coverage, and quality.

The first trend is the drive for greater quality assurance in EA services. This trend is not unique to EAPs but is universal across all health care and human service delivery systems, prompted by shrinking public and private resources and the continuous squeeze on worker benefits packages because of global competition. For both internal and

external EA programs, the new accreditation standards delivered through peer-judged investigation will be only one of many motivations to turn a critical eye on operations for compliance with best practice recommendations and more efficiency.

The second trend will be wider recognition of the acute need for realistic EA outcome measures. In addition to cost benefits, purchaser (both employer and employee "client") appraisals of EA services will be even more important. To date, most client participation surveys have been limited self-assessments conducted by EA providers. Although these surveys are considered of great value internally, the lack of standardization across data points and objective scoring are major methodological flaws that leave results open to criticism as lacking generalizability and being dangerously self-serving. IBM's EAP outcome study protocol avoids this research pitfall through its reliance on an outside vendor. Regardless of the source of the reviewer, greater incorporation of the purchasers' perspective is predicted for the future of EA outcome studies, as is increased use of this particular evaluative technique in general. One unique feature of EA outcomes research is the tension between clinical and functional outcomes as measures of performance.

The third trend is the future of EA evaluation and use of specific performance measurements. As the EA marketplace matures, both providers and purchasers will have to delineate (and ultimately agree on) specific, meaningful performance measures. Because of the EA industry's likely continued affiliation with behavioral managed care, pressure will increase from that segment for EAPs to develop industry measures in a similar manner. When coupled with increased demands for greater economies in service provision, performance measurements will be used as performance guarantees by purchasers and benchmarked in contractual agreements via a system of financial penalties.

The heightened interest in determining and incorporating program quality standards, developing meaningful performance measures, and conducting outcomes research will certainly increase demands to retool the EA industry's analytical and statistical competencies. This means providing EA professionals with the requisite level of professional development and training to accomplish needed tasks.

Looking to the future, the international arena may hold the largest untapped potential for market expansion as the EA paradigm is applied globally. The future is bright for the EA field as it assumes its role as a true profession and the accompanying responsibilities of professional development, continued research, and, most important, provision of high-quality services and programs.

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